

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
9016 CERTIFICATE OF DEATH 09001																													
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 18yrs. 10mo. 7days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3017 Barclay e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) ANGELO (NMI) BIANCERINI			4. DATE OF DEATH Month August Day 1 Year 19 61			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5-11-89			9. AGE (In years last birthday) 72 yrs.			IF UNDER 1 YEAR Months 72 Days 1 Hours 19 Min. 61								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer						10b. KIND OF BUSINESS OR INDUSTRY Railroad						11. BIRTHPLACE (County & State, or foreign country) Italy						12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I						16. SOCIAL SECURITY NO. Not available						17. INFORMANT Hospital Records, VAH, Perry Point, Md. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemic infiltration of kidneys (c) Chronic Lymphocytic leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 weeks unknown years																													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Baltimore (County) Balto. (State) Md.																	
21. I certify that ANGLO BIANCERINI attended the deceased from September 25 1942 to August 1, 1961 and that death occurred on August 1, 1961 from the causes and on the date stated above.																													
22a. SIGNATURE A. L. MOONEY						22b. DATE SIGNED 8-1-61						22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 803-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem.				23d. LOCATION (City, town or county) Balto. Md. (State)																	
24. FUNERAL DIRECTOR'S SIGNATURE John C. Miller, 2433 E. Oliver St. Baltimore, Md.						25a. REC'D BY REGISTRAR AUG 7 '61						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas																	

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For information of the Bureau, the following information is being furnished:

On 11-11-63, a letter was received from the Bureau of the Federal Bureau of Investigation, dated 11-11-63, regarding the above captioned matter.

(I)

The Bureau of the Federal Bureau of Investigation is requested to advise the Bureau of the results of its investigation.

Very truly yours,
Special Agent in Charge

John C. Miller, 2033 E. Oliver St., Baltimore, Md. 112
A. J. Fournier, Clinical Pathologist, W. Memorial Hospital, Baltimore, Md.
X

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3903 Frankford Ave			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo		c. LENGTH OF STAY IN 1b 4 hours		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle Robert Last Blackwell				4. DATE OF DEATH Month 8 Day 15 Year 1961			
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1909	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Transit Co.		11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Charles Blackwell			14. MOTHER'S MAIDEN NAME Sallie Butler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence R. Blackwell Address Baltimore, Md. Mrs. James C. Blackwell 3903 Frankford Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-15-61			
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/19/61	22c. NAME OF CEMETERY OR CREMATORY MORELAND Mem.	22d. LOCATION (City, town, or country) (State) BALTIMORE Md.	23. FUNERAL DIRECTOR L.J. Ruck		
24a. REC'D BY REGISTRAR Aug 18 '61		24b. REGISTRAR'S SIGNATURE Arthur J. Hines					

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Baltimore

Baltimore

3903 Franklin Ave

Clarence

Robert

Blackwell

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W

8-7-1909

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Bus driver

Baltimore Transit Co. Tenn

U.S.A.

James Charles Blackwell

Sally Butler

Baltimore, Md.

Mrs. James C. Blackwell 3903 Franklin Ave

Acute Coronary Occlusion

H.C. Dodson

Idaho 2nd, Md.

8-15-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9012

CERTIFICATE OF DEATH

Reg. Dist. No.

09003

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle MADLYN Last CALLAHAN		4. DATE OF DEATH Month August Day 27 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hogate		14. MOTHER'S MAIDEN NAME Lillian Arrants	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Richard M. Callahan		Address Ches. City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 4 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5 , 19 36 , to August 27 , 19 61 , that I last saw the deceased alive on Aug 27 , 19 61 , and that death occurred at 3:07 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis		DATE SIGNED 8/28/61	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		ADDRESS (Street, city or town, state) Chesapeake City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/30/61	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Near Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE AUG 31 '61	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9013

CERTIFICATE OF DEATH

Reg. Dist. No. 09005

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Elkton	
c. LENGTH OF STAY IN 1b 18 Yrs.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LE ROY GLENN COLE		4. DATE OF DEATH August 15 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward O. Cole		14. MOTHER'S MAIDEN NAME Ida Tennant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-20-9564	
INFORMANT Mrs. Iva C. Cole		Address Nr. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardiovascular disease DUE TO (c) several yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1960 , to August 15, 1961 that I last saw the deceased alive on August 11, 1961 , and that death occurred at 9:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Streetn DATE SIGNED 9/15/61			
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		23. FUNERAL DIRECTOR'S SIGNATURE Donald H. Due ADDRESS Elkton, Md.	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		24a. REC'D BY REGISTRAR AUG 17 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Harris	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/61	
22c. NAME OF CEMETERY OR CREMATORY Fair View Cemetery		22d. LOCATION (City, town, or county) (State) Thompson, Penna.	

CERTIFICATE OF DEATH

2013

Coronary thrombosis
Atherosclerotic hypertensive
cardiovascular disease

August 18, 2013

2:30a

01

August 11

233 E. Main Street

Albany, New York

Dr. J. H. Anderson, Jr., M.D.

Dr. J. H. Anderson, Jr.

Physician

Albany, New York

Albany, New York

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, the delay should be noted in the space provided. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9014

09006

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Delaware b. COUNTY Newcastle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington Rural		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ---			d. STREET ADDRESS 41X		
3. NAME OF DECEASED (Type or print) First Middle Last Virginia H Davidson			4. DATE OF DEATH Month Day Year August 25 19 61		
5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH Oct. 20, 1920		
9. AGE (In years last birthday) 40			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pvt. Secretary			10b. KIND OF BUSINESS OR INDUSTRY Oil Ref. Catalytic		
11. BIRTHPLACE (State or foreign country) Denton, Maryland			12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Edward Pennington Horsey			14. MOTHER'S MAIDEN NAME Grace May Hubbard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 222-10-5960			17. INFORMANT Paul B. Horsey, Possum Point Rd., Dunfries, Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Compound fracture of both legs and both arms, face and crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Car ran into abutment on Route 40 and Big North East Creek on east bound lane (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH None		
20c. TIME OF INJURY Month, Day, Year 1:50 hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East			20f. (City or town) (County) (State) Cecil Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED Aug 25, 1961					
EXAMINER'S SIGNATURE R. C. Dodson, M.D.					
EXAMINER'S NAME (Type) R. C. Dodson, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 8-28-61					
22c. NAME OF CEMETERY OR CREMATORY Denton Cemetery					
22d. LOCATION (City, town, or country) (State) Denton Md.					
23. FUNERAL DIRECTOR J. Harvey Williamson					
ADDRESS Federalburg, Md					
24a. REC'D BY REGISTRAR AUG 28 '61					
24b. REGISTRAR'S SIGNATURE Arthur L. Hume					

3101

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(I)

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Manner of death: [illegible]
9. Signature of medical examiner: [illegible]
10. Date of certification: [illegible]

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09007

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CECILTON c. LENGTH OF STAY in lb 10 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLETOWN R.D.2 d. STREET ADDRESS Lilly Davis, Middletown R.D.2. Del. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE P DAVIS		4. DATE OF DEATH Month Day Year 8 29 19 61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-1908
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days 53	
11. IF UNDER 24 HRS. Hours Min. 53		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Davis		14. MOTHER'S MAIDEN NAME Lilly Pierce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. Lilly Davis, Middletown R.D.2. Del.	
17. INFORMANT Lilly Davis, Middletown R.D.2. Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-29-61 ACTUAL SIGNATURE R.C. Dodson EXAMINER'S NAME (Type) R.C. Dodson Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 2, 1961	
22c. NAME OF CEMETERY OR CREMATORY Forest Cemetery		22d. LOCATION (City, town, or country) (State) Middletown Del.	
23. FUNERAL DIRECTOR Edward Bullock		24a. REC'D BY REGISTRAR SEP 5 '61	
24b. REGISTRAR'S SIGNATURE William M. Mullington		24c. REGISTRAR'S SIGNATURE William M. Mullington	

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9016

CERTIFICATE OF DEATH

Reg. Dist. No. 18008

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRATT NURSING HOME</u>		d. STREET ADDRESS <u>1 LANDING LANE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MARY DEIBERT</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 31 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27, 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE B. DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>JULIA HITCHENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>C. ELLIS DEIBERT</u>		Address <u>ELKTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular Failure</u> <u>572X</u> DUE TO <u>A.S.C. V. D. Decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Glomerulo Nephritis & Uremia</u> (c) <u>Chronic Cholecystitis & Chronic R. Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u> <u>Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholecystitis & Chronic R. Arthritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-5-</u> , 19 <u>58</u> , to <u>8-31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-30</u> , 19 <u>61</u> , and that death occurred at <u>8:25</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cecil Ave.</u> DATE SIGNED <u>Luis M. Cuza</u>			
ACTUAL SIGNATURE <u>Luis M. Cuza</u>		M.D. <u>Cecil Ave.</u>	
PHYSICIAN'S NAME (Type) <u>LUIS M. CUZA M.D.</u>		<u>NORTH EAST Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 3, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ELKTON, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>ELKTON Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Julius S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2018

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		DATE OF BIRTH [Faint text, possibly "01/01/1950"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "03/15/2018"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	

RECEIVED

BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09009

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown (Rural)</u> c. LENGTH OF STAY in 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) --				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Pennsylvania</u> b. COUNTY <u>Berks</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oley Township</u> d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First <u>Horace</u> Middle <u>D</u> Last <u>Dry</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 21, 1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u>			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		13. BIRTHPLACE (State or foreign country) <u>Hereford, Pa</u>			
14. CITIZEN OF WHAT COUNTRY? <u>USA</u>		15. FATHER'S NAME <u>Hiriam Dry</u>		16. MOTHER'S MAIDEN NAME <u>Hettie Boyer</u>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>SS 180-20-3513</u>		19. INFORMANT <u>Mrs Deborah DeTurck, Oley Township, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Aug. 14, 1961.</u>			
EXAMINER'S NAME (Type) <u>R.C. Dodson, M.D.</u>		Address (Street, city, town, or county) <u>Rising Sun, Maryland</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>Aug. 18, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frieden's Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Oley Township Pa</u>			
23. FUNERAL DIRECTOR <u>Joseph A. Grant</u>		24a. REC'D BY REGISTRAR <u>Aug 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it may be extended by the State Board of Health. File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR INFO
SOUTH WY

2012

2012 MEDICAL EXAMINER CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH & HUMAN SERVICES

STATE OF NEW YORK

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is oriented horizontally but contains vertical text columns.

Vertical text on the right margin, likely a filing or tracking number, oriented vertically.

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3018											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 32yrs.8mo.27days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 742 - 5th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE A. DURST				4. DATE OF DEATH Month August Day 9 Year 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-4-74		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Post Office				11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James G. Durst (deceased)				14. MOTHER'S MAIDEN NAME Anna Forrestelle (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes S.A.W.				16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
1. Chronic Bronchitis. 2. Pulmonary Emphysema. 3. Arteriosclerosis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) generalized							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that the deceased attended the deceased from November 13 19 28 to August 9, 19 61 and that death occurred at 11:10pm from the causes and on the date stated above.											
22a. SIGNATURE S. Goldgraben				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 8-10-61			
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, Chief, Medical Service, VA Hospital, Perry Point, Md.				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 11/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun.Home, 4101 Edmondson Ave. Balto. Md.				ADDRESS 4101 Edmondson Ave. Balto. Md.				25a. REC'D BY REGISTRAR Aug 14 61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1
FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
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5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9019 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09011											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY IN 1b 1 yr. 25 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1907-W. North Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LARRY N. ENGLISH				4. DATE OF DEATH 8 16 19 61							
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-28		9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Winston-Salem, N.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Nathan Searcy				14. MOTHER'S MAIDEN NAME Lillian (?) English							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II				16. SOCIAL SECURITY NO. 219-28-6046		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: MANGLED BODY											
IMMEDIATE CAUSE (a) 979X DUE TO STRUCK BY TRAIN											
Conditions, if any, which gave rise to immediate cause (b) DUE TO											
(c) stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 6:15 p.m. 8-16 19 61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Struck by train Perryville Cecil Md.		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. DODSON, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				8/16/61			
EXAMINER'S NAME (Type) R.C. DODSON, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Aug. 21, 1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave. Balto. Md.				24a. REC'D BY REGISTRAR AUG 21 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09012

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Salem	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY in 1b 1 mo. 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 126 Thompson 67X-3	
3. NAME OF DECEASED (Type or print) JOHN (NMI) FAHRNER		4. DATE OF DEATH August 10 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-95
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Fahrner		14. MOTHER'S MAIDEN NAME Flora Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Suffocation by drowning. 929.8 DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2. Cataracts, bilateral.			INTERVAL BETWEEN ONSET AND DEATH Less than 10 minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 7: 8 10 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River	20f. (City or town) Perry Point, Md. (County) Cecil (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. DODSON		DATE SIGNED 8/10/61	
EXAMINER'S NAME (Type) R.C. DODSON		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-61	
22c. NAME OF CEMETERY OR CREMATORY Presbyterian		22d. LOCATION (City, town, or country) Salem (State) N.J.	
23. FUNERAL DIRECTOR Norman S. Newkirk, 54 Oak St. Salem, N.J.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
24a. REC'D BY REGISTRAR AUG 14 '61		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF MEDICAL SERVICE
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9021

CERTIFICATE OF DEATH

09013

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 mo. 9 days		d. STREET ADDRESS 12820 Holdridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FLOYD M. HANNA				4. DATE OF DEATH Month Day Year August 14 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-09	
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas M. Hanna				14. MOTHER'S MAIDEN NAME Sarah Bryant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-II				16. SOCIAL SECURITY NO. 579-12-0649			
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & congestion, bilateral, severe (b) Adenocarcinoma of the rectum with metastasis to the liver (c) to the liver INTERVAL BETWEEN ONSET AND DEATH 2-3 days unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (the deceased) attended the deceased from June 5, 1961 to August 14, 1961 and that death occurred at 10:35 a.m. from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney				22b. DATE SIGNED 8-15-61		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 8/16/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Berninger Bros., Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE AUG 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9022

CERTIFICATE OF DEATH

Reg. Dist. No.

09014

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>40 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital, Elkton, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles L. Kane</u>		4. DATE OF DEATH Month Day Year <u>August 24, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/1891</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Queen Anne's, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kane</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>212-18-2315</u>	
17. INFORMANT <u>Mrs. Geraldine Kane</u>		18. ADDRESS <u>214 East High St. Elkton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Pneumonia</u> DUE TO (b) <u>Pulmonary Congestion</u> DUE TO (c) <u>Acute Nephritis and Acute Gastritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1-Day</u> <u>1-Day</u> <u>3-Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 22, 1961</u> to <u>August 25, 1961</u> , that I last saw the deceased alive on <u>August 25, 1961</u> and that death occurred at <u>8 A:</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>245 East High Street 8/26/61</u>			
ACTUAL SIGNATURE <u>James L. Johnson</u>		M.D. <u>245 East High Street 8/26/61</u>	
PHYSICIAN'S NAME (Type) <u>James L. Johnson M. D.</u>		<u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bohemia Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Bell</u>		ADDRESS <u>909 Poplar St.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF LEAD

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9022 MEDICAL RESEARCH'S ESTIMATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point 36 yrs c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Pennsylvania b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh d. STREET ADDRESS 2256 Almont			
3. NAME OF DECEASED (Type or print) First FRED Middle (NMI) Last LOEFFEL		4. DATE OF DEATH Month August Day 18 Year 19 61		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-91	9. AGE (In years at birthday) 69 yrs.	IF UNDER 1 YEAR Months 75 Days X-3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Steel Corporation		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alexander Loeffel			14. MOTHER'S MAIDEN NAME Rosina (?) Loeffel				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/branch/dates of service) Yes WW-I		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary edema and congestion, severe DUE TO (b) Arteriosclerotic heart disease DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 3-4 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis generalized severe					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that J. L. Garey attended the deceased from August 29, 1951 , to August 18, 1961 and that death occurred at 3:15 pm from the causes and on the date stated above.							
22a. SIGNATURE J. L. Garey				22b. DATE SIGNED 8-18-61			
22c. PHYSICIAN'S NAME (Type) J. L. GAREY				22d. ADDRESS Clinical Pathologist, V.A. Hospital, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 8/19/1961		23c. NAME OF CEMETERY OR CREMATORY Zimmerman			
23d. LOCATION (City, town or county) Pittsburgh, Pa.							
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				25a. RECD BY REGISTRAR AUG 22 61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9025 CERTIFICATE OF DEATH 09017									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge c. LENGTH OF STAY IN lb 1 day 8 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, USNTC					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 234-Al Laffey Circle, Manor Heights e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Richard		First		Middle		Last Frank Manteufel, Jr.		4. DATE OF DEATH August 22 1961	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 21, 1961		9. AGE (In years last birthday) yrs. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Frank Manteufel					14. MOTHER'S MAIDEN NAME Masako (n) Soejima				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X PREMATURE BIRTH, NEONATAL DEATH DUE TO (b) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) --- DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ---								INTERVAL BETWEEN ONSET AND DEATH 32 hr. 30 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---							
20c. TIME OF INJURY Hour a.m. 19 p.m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 21, 1961 to August 22, 1961 , that (I) (we) last saw the deceased alive on August 22, 1961 , and that death occurred at 5:00 PM , from the causes and on the date stated above.									
22a. SIGNATURE Gordon B. Avery M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-23-61	
22c. PHYSICIAN'S NAME (Type) GORDON B. AVERY LT MC USN		22d. ADDRESS Station Hospital U.S. Naval Training Center, Bainbridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-61		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery		23d. LOCATION (City, town or county) Colora		(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE LEE A. PATTERSON & SON		ADDRESS Perryville, Maryland		25a. REC'D BY REGISTRAR 8/23/61		25b. REGISTRAR'S SIGNATURE Arthur L. Huns		DATE AUG 24 '61	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9025											
09018											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 25yrs 26days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 9648 Alda Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ALBERT Middle L. Last MAPUS						4. DATE OF DEATH Month August Day 30, Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 20, 1900		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Bakery				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HENRY MAPUS						14. MOTHER'S MAIDEN NAME ISABELLE CREAMER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-1				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH., Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Heart DUE TO Due to Acute Myocardial infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Coronary thrombosis DUE TO Coronary thrombosis										INTERVAL BETWEEN ONSET AND DEATH 2 to 5 Min. 4 to 6 days " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Generalized											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (a) (this hospital) attended the deceased from August 4, 1961 , to August 30, 1961 that (b) (we) last saw the deceased alive on August 30, 1961 , and that death occurred at 2:35 PM from the causes and on the date stated above.											
22a. SIGNATURE A.L. Mooney M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-31-61			
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, M.D., Asst. Clinical Pathologist, VAH., Perry Point, Md.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-2-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Ruck				ADDRESS 5305 Harford Rd., Baltimore 14, Md.				25a. REC'D BY REGISTRAR SEP 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

0025

(M)

Geoff

Ferry Point

25 yrs 10 days

Baltimore

Maryland

Veterans Administration Hospital

9248 11th Drive

ALBERT

L.

MAYUS

August 30,

White

x

October 20, 1900

60

Barber

Bakery

Maryland

USA

JOHN HENRY MAYUS

IRRAWADDI CHAMBER

Yes

W-1

None

Hospital Records, V.A., Ferry Point, Md.

Signature of Henry

Due to acute myocardial infarction

Coronary thrombosis

Arteriosclerosis Generalized

August 30, 61

August 11, 56
2:55PM

August 30, 61

8-31-61

x

Q. L. Mowery

A. L. MOONEY, M.D., Asst. Clinical Pathologist, V.A., Ferry Point, Md.

Exhibit 1 8-2-61

Baltimore National

Baltimore, Maryland

2505 N. Main St.,
Baltimore 14, Md.

LUCK FORNARD HOME

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Penna. b. COUNTY Delaware			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charlestown		c. LENGTH OF STAY in 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Haverford		75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wellwood Marina				d. STREET ADDRESS 306 D Haverford Villa Apts.			
3. NAME OF DECEASED (Type or print) HENRY FREDERICK MARQUARDT				4. DATE OF DEATH Aug. 28, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1905	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY School Supplies		11. BIRTHPLACE (State or foreign country) Elizabeth, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry F. Marquardt				14. MOTHER'S MAIDEN NAME Elfrida No Information			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Eve Marquardt, Haverford, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. POPSON		M.D. DEPUTY MEDICAL EXAMINER Rising Sun, Md.		DATE SIGNED 8/28/61			
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-31-61	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or country) (State) Elizabeth, N. J.			
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		ADDRESS Donald M. De Elktion, Md.		24a. REC'D BY REGISTRAR AUG 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

4

9028

CERTIFICATE OF DEATH

Reg. Dist. No. 09020

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA. b. COUNTY CHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTCHESTER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL				d. STREET ADDRESS 75X3			
3. NAME OF DECEASED (Type or print) First Middle Last ORVILLE GRACE McCASLIN				4. DATE OF DEATH Month Day Year AUGUST 10 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1893		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISSAFAHAR McCLAIN				14. MOTHER'S MAIDEN NAME SARA PEOPLES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		INFORMANT Address Mrs. Joseph Orr, Rising Sun, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis DUE TO (c) atherosclerosis, GAS							INTERVAL BETWEEN ONSET AND DEATH 24 hrs unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9 Aug , 19 61 , to 10 Aug , 19 61 that I last saw the deceased alive on 10 Aug , 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above.							DATE SIGNED 10 Aug 61
ACTUAL SIGNATURE Robert W. Ireland		M.D. P.O. Box 446 Rising Sun		ADDRESS (Street, city or town, state) Rising Sun, Md.			
PHYSICIAN'S NAME (Type) Robert W. Ireland MD		ADDRESS Rising Sun, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/1961	22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (city, town, or county) (State) Colorado Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ralph McReed				24a. REC'D BY REGISTRAR DATE AUG 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES
MARINE CORPS
OFFICE OF THE
JUDGE ADVOCATE GENERAL
WASHINGTON, D. C.

UNITED STATES

OFFICE

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

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UNITED STATES

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9030 CERTIFICATE OF DEATH 09022

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 34yrs.8mo.20days		d. STREET ADDRESS 2813 Bellevue Terrace, N. W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK (NMI) PACH		4. DATE OF DEATH Month Day Year August 7 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-89
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William Poch		14. MOTHER'S MAIDEN NAME Pauline Auth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (a), stating the underlying cause last. DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 10-15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that XXXXXXXXXXXX attended the deceased from XXXXXXXXXXXX November 18 1926, to XXXXXXXXXXXX August 7, 1961, and that death occurred on XXXXXXXXXXXX August 7, 1961, at XXXXXXXXXXXX 6:30am from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D.			
22b. DATE SIGNED 8-7-61			
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.			
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 8-9-1961			
23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) (State) Arlington, Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers Sons, 1756 Penna Ave. NW			
25a. REC'D BY REGISTRAR DATE AUG 9 '61			
25b. REGISTRAR'S SIGNATURE			

0030

(M)

0031

Director of Central

Washington

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

THIS BELIEVES

Government Administration

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White House

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TO HO...AL OR A...NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9031 CERTIFICATE OF DEATH 09023											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware b. COUNTY New Castle					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home						d. STREET ADDRESS 78 Kells Avenue					
3. NAME OF DECEASED (Type or print)			First Middle Last Lola Ellis Phillips			4. DATE OF DEATH Month Day Year 8-22-61 19					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1879		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Ellis						14. MOTHER'S MAIDEN NAME Ann Virginia Phillips					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Claude E. Phillips			67 Kells Ave Newark, Del.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerosis, cerebral 4 yrs DUE TO (c) Generalized arteriosclerosis 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Newark		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 10, 1959, to Aug 22, 1961, that (I) (we) last saw the deceased alive on Aug 22, 1961, and that death occurred at 2:12 PM from the causes and on the date stated above.											
22a. SIGNATURE Wallace M. Johnson						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Wallace M. Johnson						22d. ADDRESS 257 E Main St Newark Del.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-25-61		23c. NAME OF CEMETERY OR CREMATORY Ralph's Hill Cemetery				23d. LOCATION (City, town or county) (State) Delmar, Delaware			
24. FUNERAL DIRECTOR'S SIGNATURE William J. Warwick						ADDRESS Newark, Dela.		25a. REC'D BY REGISTRAR AUG 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

9631

M

I

WILLIAM J. WARWICK

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9032

09024

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Principio Furnace, Rural				c. LENGTH OF STAY IN 1b 14 Yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Lane				d. STREET ADDRESS Station Lane			
3. NAME OF DECEASED (Type or print) Francis H. Smith				4. DATE OF DEATH Month Aug. Day 29 Year 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1900	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-03-3111		17. INFORMANT Jane Hammond		Address Principio Furnace, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11, 1960 to Aug. 29, 1961 , that (I) (we) last saw the deceased alive on Aug. 29, 1961 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE George T. Stansbury M.D.				22b. DATE SIGNED 8/30/61			
22c. PHYSICIAN'S NAME (Type) George T. Stansbury, M.D.				22d. ADDRESS 569 Revolution Street Havre de Grace, Maryland			
23a. BURIAL CREMATION, REMAINS (Specify) Burial		23b. DATE THEREOF Sept. 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Jones Memorial Cem. Port Deposit, Md. Rural		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Lee's Patterson & Son ADDRESS Perryville, Md				25a. REC'D BY REGISTRAR DATE SEP 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

0032

Cecil

Maryland

Cecil

Principio Terrace, Rural 11 Yrs Principio Terrace, Rural

Section Lane Section Lane

Francis H. Cecil Aug. 29 61

Male Colored X May 5, 1900 61

Laborer Day Maryland U.S.A.

Unknown Unknown

212-02-2111 Jane Harmona Principio Terrace, Md.

Cerebral thrombosis

Hypertensive cerebrovascular heart disease

June 11, 60 2/25/61 61

6/30/61

George E. Scannery, M.D. 309 Revolution Street
Baltimore, Md. 21201

George E. Scannery, M.D. 309 Revolution Street

Fort Valley, Ga 31701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9033

CERTIFICATE OF DEATH

Reg. Dist. No. 09025

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph J. Speakman, Sr.		4. DATE OF DEATH Month Day Year August 17, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1895
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Thiokol Corp.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Speakman		14. MOTHER'S MAIDEN NAME Carrie Shade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT Address R.D. 3 Mrs. Anna Chidester Speakman, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular hemorrhage 443X DUE TO Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 14, 19 61 to August 17, 19 61, that I last saw the deceased alive on August 16, 19 61, and that death occurred at 2:45a, from the causes and on the date stated above.		DATE SIGNED 8/17/61	
ACTUAL SIGNATURE S. RALPH ANDREWS, JR., M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street Elkton Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/61	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Union, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 25 '61			

CERTIFICATE OF DEATH

1933

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9034

CERTIFICATE OF DEATH

Reg. Dist. 09026

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>		c. LENGTH OF STAY IN 1b <u>45 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIA PASLAWSKI STATKAVIG</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 3 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>UKRAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No INFO</u>		14. MOTHER'S MAIDEN NAME <u>No INFO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT Address <u>Mrs. ESTELLE LUZETSKY CHESAPEAKE CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>gastro hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>6 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 10</u> , 19 <u>61</u> , to <u>Aug 3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>61</u> , and that death occurred at <u>10:40 AM</u> from the causes and on the date stated above.		DATE SIGNED <u>8/8/61</u>	
ACTUAL SIGNATURE <u>Henry V. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY MD</u>	
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/5/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. ROSES</u>		22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>ELKTON, MD</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 8, '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>William A. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2034

DECLARATION OF DEATH

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1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Signature of declarant: [illegible]
6. Date of declaration: [illegible]
7. Signature of physician: [illegible]
8. Date of signature: [illegible]
9. Signature of medical examiner: [illegible]
10. Date of signature: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9035

CERTIFICATE OF DEATH

09027

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY in 1b 1 mo 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 4104 Gallatin	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLEN Middle LAVERNE Last SUIT		4. DATE OF DEATH Month August Day 1 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-20-01	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett M. Suit (deceased)		14. MOTHER'S MAIDEN NAME Hannah E. Allen (deceased)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II		16. SOCIAL SECURITY NO. 579-07-6021		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic anaplastic carcinoma DUE TO (b) (primary site undetermined) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. B.S. Linn attended the deceased from June 30, 1961, to August 1, 1961, and that death occurred at 7:00 PM on the causes and on the date stated above.							
22a. SIGNATURE B.S. Linn		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-2-61	
22c. PHYSICIAN'S NAME (Type) B.S. LINN		Chief Resident, Surgical Service, VAH, Perry Point, Md.		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 4-61		23c. NAME OF CEMETERY OR CREMATORY Epiphany		23d. LOCATION (City, town or county) (State) Forrestville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR DATE AUG 4 '61		25b. REGISTRAR'S SIGNATURE William S. Thane	
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09028

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON				c. LENGTH OF STAY IN 1b 9 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HORACE WILLARD TAYLOR				4. DATE OF DEATH Month Day Year AUG. 23, 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/6/1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER RET. SELF EMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED			
13. FATHER'S NAME JOHN TAYLOR				14. MOTHER'S MAIDEN NAME FRANCES FLAHERTY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-01-6605		17. INFORMANT RALPH TAYLOR Address 14th ST. OCEAN CITY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid Colon & Metastasis DUE TO (b) 153.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 16, 1961 to Aug 23, 1961 , that (I) (we) last saw the deceased alive on Aug 22, 1961 , and that death occurred on Aug 23, 1961 at 8:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE Frank D. Hauber				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 24, 1961	
22c. PHYSICIAN'S NAME (Type) Frank D. Hauber, M. D.				22d. ADDRESS 611 South Union Ave., Havre De Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/26/1961		23c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM		23d. LOCATION (City, town, or county) (State) COLORA MD:	
24. FUNERAL DIRECTOR'S SIGNATURE Wm E. Mullen				25a. REC'D BY REGISTRAR RISING, SUN, MD.		25b. REGISTRAR'S SIGNATURE Arthur J. Smith	

JOHN TAYLOR
 CARPENTER RET. SELF EMPLOYED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9037

CERTIFICATE OF DEATH

09029

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leeds</u> d. STREET ADDRESS <u>Leeds</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leeds</u>				c. LENGTH OF STAY IN life <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(SARAH) First Middle Last</u> <u>Sadie Bell Thompson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1871</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>61</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>Companion</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>168-30-2210</u>		17. INFORMANT <u>Mr. Elmer Jermyn, Elkton, Md. R.D.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO <u>420-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Block</u> (c) <u>Arteriosclerotic Heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>15 minutes</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>61</u> , to <u>7/7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Randall Ross</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS, M.D.</u>				22d. ADDRESS <u>Elkton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Grove, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Reph E. Hicks</u> ADDRESS <u>Elkton, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 14 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9038											
CERTIFICATE OF DEATH											
09030											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY in lb 2 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bronx				d. STREET ADDRESS 2706 Kingsbridge Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELEANOR (NMI) THORNE			First Middle Last			4. DATE OF DEATH August 8 19 61			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-11-71		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10b. KIND OF BUSINESS OR INDUSTRY Private Duty		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Armstrong						14. MOTHER'S MAIDEN NAME Elizabeth (?)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 5-10 Minutes 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease, Severe (Years) (c) Arteriosclerosis, Generalized (Years) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of left foot										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that the deceased attended the deceased from August 14, 1959, to August 8, 1961, that (1) (two) last saw the deceased alive on August 14, 1959 and that death occurred at 5:50 p.m. from the causes and on the date stated above.											
22a. SIGNATURE A. L. MOONEY						M.D.		22b. ADDRESS A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.		22c. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)											
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b. DATE THEREOF 8/14/1961			23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Birmingham, Ala. Home						ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
09031											
1. PLACE OF DEATH a. COUNTY Cecil						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashland c. LENGTH OF STAY in lb few days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Nazerine Camp Grounds					
3. NAME OF DECEASED (Type or print) Mabel						4. DATE OF DEATH Month 8 Day 6 Year 19 61					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-12-1900		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Pa.		
13. FATHER'S NAME Michael Kessler						14. MOTHER'S MAIDEN NAME Laura Slotterback					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 200-32-8895			17. INFORMANT Wilbur Tietsworth, Ashland, Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md. Address (Street, city, town, or county)											
ACTUAL SIGNATURE		DATE SIGNED 8-6-61									
EXAMINER'S NAME (Type) R.C. Dodson											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-1961		22c. NAME OF CEMETERY OR CREMATORY Mabel U. B		22d. LOCATION (City, town, or country) (State) Mabel Schuykill Co. Pa					
23. FUNERAL DIRECTOR Joseph R Grant North East. Md						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
DATE AUG 9 '61											

THE STATE
OF NEW YORK



2028

2028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Date of Death: [illegible]
3. Place of Death: [illegible]

4. Cause of Death: [illegible]
5. Manner of Death: [illegible]

6. Signature of Medical Examiner: [illegible]
7. Date of Examination: [illegible]

8. Signature of Coroner: [illegible]
9. Date of Certification: [illegible]

10. Signature of Registrar: [illegible]
11. Date of Registration: [illegible]

12. Signature of [illegible]: [illegible]
13. Date of [illegible]: [illegible]

14. Signature of [illegible]: [illegible]
15. Date of [illegible]: [illegible]

16. Signature of [illegible]: [illegible]
17. Date of [illegible]: [illegible]

18. Signature of [illegible]: [illegible]
19. Date of [illegible]: [illegible]

20. Signature of [illegible]: [illegible]
21. Date of [illegible]: [illegible]

22. Signature of [illegible]: [illegible]
23. Date of [illegible]: [illegible]

24. Signature of [illegible]: [illegible]
25. Date of [illegible]: [illegible]

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27. Date of [illegible]: [illegible]

28. Signature of [illegible]: [illegible]
29. Date of [illegible]: [illegible]

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33. Date of [illegible]: [illegible]

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39. Date of [illegible]: [illegible]

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43. Date of [illegible]: [illegible]

44. Signature of [illegible]: [illegible]
45. Date of [illegible]: [illegible]

46. Signature of [illegible]: [illegible]
47. Date of [illegible]: [illegible]

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09032

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY in lb 8 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East Rural		d. STREET ADDRESS Shadow Trailer Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Randall D Ward				4. DATE OF DEATH Month Day Year Aug. 24 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1957	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Days 11		11. IF UNDER 24 HRS. Hours Min. 11		12. CITIZEN OF WHAT COUNTRY USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Grundy, Virginia	
13. FATHER'S NAME Lonzo T. Ward				14. MOTHER'S MAIDEN NAME Roaslie Fleming			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --				16. SOCIAL SECURITY NO. --		17. INFORMANT Lonzo T. Ward, Shadow Trailer Park, North East	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis from ruptured intestine 835X DUE TO Fracture of Pelvis Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 8 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell off Milk Truck - (was moving)			
20c. TIME OF INJURY Month, Day, Year 10 AM 8-16-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shadow Trailer Park North East Cecil Md. (Rural)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Allred				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 8-25-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-61		22c. NAME OF CEMETERY OR CREMATORY Grundy Va.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Joseph R. Grant North East, Maryland				24a. REC'D BY REGISTRAR AUG 28 '61		24b. REGISTRAR'S SIGNATURE C. L. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 292 8-16-61 ams											
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
9041											
CERTIFICATE OF DEATH											
Reg. Dist. No. 09033											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perryville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broad St.						d. STREET ADDRESS Broad St.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Grace First Middle S. Warner Last						4. DATE OF DEATH Month Aug. Day 8 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John W. Cochran						14. MOTHER'S MAIDEN NAME Araminta Fray					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Donald Cole Sr., Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.5 Cerebro-vascular Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative pining of fractured hip DUE TO (c) 5 minutes 5 weeks.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell down coming out of church 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 7-2-61 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street - Church 20f. (City or town) Perryville (County) Cecil (State) Md.											
21. I certify that I attended the deceased from 7-1, 1961, to 8-8, 1961, that I last saw the deceased alive on 8-3, 1961, and that death occurred at 6:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8-9-1961 DATE SIGNED ACTUAL SIGNATURE Gunther D. Hirsch M.D. Havre De Grace, Md. PHYSICIAN'S NAME (Type) Gunther D. Hirsch M.D. Havre De Grace, Md.											
22a. BURIAL, CREMATION, or other disposal (Specify) Burial				22b. DATE THEREOF 8-10-1961		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery				22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, ADDRESS Perryville, Md.						24a. REC'D BY REGISTRAR DATE AUG 11 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

CERTIFICATE OF DEATH

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NAME		LAST		FIRST		MIDDLE	
JAMES		JAMES		JAMES		JAMES	
AGE		SEX		RACE		RELIGION	
65		M		W		C	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAN 1 1890		NEW HAMPSHIRE		JAN 1 1955		NEW HAMPSHIRE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES J. JAMES		JAMES J. JAMES		JAMES J. JAMES		JAMES J. JAMES	
DATE		TIME		PLACE		CITY	
JAN 1 1955		10:00 AM		NEW HAMPSHIRE		NEW HAMPSHIRE	
REGISTRATION NO.		FILING NO.		FILING NO.		FILING NO.	
1000		1000		1000		1000	

9042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09034

MEDICAL CERTIFICATION

VS. A15ME
5M 9/60

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09035

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE N. J. b. COUNTY Gloucester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural North East		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glassboro	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Elk Neck State Park		d. STREET ADDRESS 410 Franklin Road	
3. NAME OF DECEASED (Type or print) First John Last Charles Weir		4. DATE OF DEATH Month 8 Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 4, 1941
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Cloiser	11. BIRTHPLACE (State or foreign country) N.J.
13. FATHER'S NAME John W. Weir		14. MOTHER'S MAIDEN NAME Carolyn Minton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 142-32-2110	
17. INFORMANT John W. Weir		Address 410 Franklin Rd Glassboro N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 890.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) charcoal stove burning in small closed tent (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State park	20f. (City or town) (County) (State) Rural North East, Cecil, Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> R.C. Dodson ACTUAL SIGNATURE EXAMINER'S NAME (Type) R.C. Dodson Rising Sun, Md CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 9, 1961 Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or other (Specify) BURIAL	22b. DATE THEREOF 8-12-1961	22c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park	22d. LOCATION (City, town, or country) (State) East Pitman, Gloucester, NJ
23. FUNERAL DIRECTOR Joseph R. Grant Joseph R. Grant North East, Maryland		24a. REC'D. BY REGISTRAR DATE AUG 14 '61 24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9044

09036

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b 37yrs. 11mo. 12days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware b. COUNTY Wilmington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1807 Green Lane, Arden d. STREET ADDRESS 1807 Green Lane, Arden e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT F. WHITESIDE		4. DATE OF DEATH Month August Day 22 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-96	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather Cutter		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Leather Establishment	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not available		14. MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 (b) Calcification of aortic valve (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 10-15 min. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis generalized severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. L. L. Moore attended the deceased from September 10, 1961 to August 22, 1961, that Dr. L. L. Moore and that death occurred 1:30 pm from the causes and on the date stated above.			
22a. SIGNATURE A. L. MOONEY		22b. DATE SIGNED 8-23-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) W		23b. DATE THEREOF 8/24/61	
23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens		23d. LOCATION (City, town or county) (State) Arden, Wilmington, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. RECORD BY REGISTRAR'S SIGNATURE Aug 28 61	

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15M 9/60

(M)

(1)

Geoff

Delaware

Perry Point

Styria, 124-45

Wilmington

Government Administration Hospital

1907 Green Lane, London

HOLMES

F.

WILKINSON

August 22

61

knife

white

2-30-36

82

Leather Cutter

Establishment

Wholesale Leather

USA

Not available

Not available

Yes

W-I

unknown

Hospital Records, V.A., Perry Point, Md.

Ventricular arrhythmia

10-15 min.

Calcification of aortic valve

unknown

Arteriosclerotic heart disease

unknown

Arteriosclerosis generalized severe

X

VA

September 10 22 August 22 61

1:30 pm

XXXXXXXXXXXXXXXXXXXX

8-23-61

X

Handwritten signature

A. E. MURPHY, Asst. Clinical Pathologist, V.A., Perry Point, Md.

Wilmington, Delaware, U.S.A.